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Communication Between Physicians And Spanish-Speaking Latin American Women With Pelvic Floor Disorders: A Cycle Of Misunderstanding?

Claudia Sevilla¹, Cecilia K. Wieslander, MD², Alexandriah N. Alas, MD³, Gena C. Dunivan, MD⁴, Aqsa A. Khan, MD¹, Sally L. Maliski RN, PhD⁵, Rebecca G. Rogers, MD⁴, and Jennifer T. Anger, MD, MPH⁶

¹Department of Urology, UCLA David Geffen School of Medicine, Los Angeles, CA, United States

²Department Obstetrics and Gynecology, Olive View-UCLA Medical Center, Sylmar, CA, United States

³Department of Obstetrics and Gynecology, Cedars-Sinai Medical Center, Los Angeles, CA, United States

⁴Department of Obstetrics and Gynecology and Department of Surgery, University of New Mexico Health Sciences Center, Albuquerque, NM, United States

⁵UCLA School of Nursing, Los Angeles, CA, United States

⁶Department of Urology, Cedars-Sinai Medical Center, Los Angeles, CA, United States

Abstract

Objectives—To assess the effect of the initial visit with a specialist on disease understanding among Spanish-speaking women with pelvic floor disorders.

Methods—Spanish-speaking women with referrals suggestive of urinary incontinence (UI) and/or pelvic organ prolapse (POP) were recruited from public urogynecology clinics. Patients participated in a health literacy assessment and interview before and after their physician encounter. All interviews were analyzed using Grounded Theory qualitative methods.

Results—Twenty-seven women with POP (N=6), UI (N=11), and POP/UI (N=10) were enrolled in this study. The mean age was 55.5 years and the majority of women had marginal levels of health literacy. From our qualitative analysis, three concepts emerged. First, was that patients had poor understanding of their diagnosis before and after the encounter regardless of how extensive the physician's explanation or level of Spanish-proficiency. Secondly, patients were overwhelmed with the amount of information given to them. Lastly, patients ultimately put their trust in the physician, relying on them for treatment recommendations.

Conclusions—Our findings emphasize the difficulty Spanish-speaking women with low health literacy have in understanding information regarding pelvic floor disorders. In this specific population, the physician has a major role in influencing patients' treatment decisions and helping them overcome fears they may have about their condition.

Keywords

Pelvic Prolapse; Incontinence; Qualitative Methods; Health Literacy; Disease Understanding

INTRODUCTION

The burden of pelvic floor disorders on aging women is immense in both human and financial terms. Pelvic floor disorders (PFD) s include urinary incontinence (involuntary leakage of urine), pelvic organ prolapse (the descent of the anterior vaginal wall, posterior vaginal wall, or apex of the vagina) and fecal incontinence.¹ Urinary incontinence may be classified into stress urinary incontinence (SUI), leakage on effort, exertion, sneeze or cough; or urgency urinary incontinence (UI), leakage that occurs with an urge to void.^{1,2} Urinary incontinence (UI) and pelvic organ prolapse (POP) represent conditions most commonly treated surgically.²

The burden of PFDs may be more substantial for women of Hispanic descent, who bear a disproportionate number of symptomatic pelvic floor disorders compared with other ethnic groups. A population-based cohort study of 2,270 women identified a 4-5 times higher risk of symptomatic pelvic prolapse among Latina and White women compared with African American women.³ A second population-based study in Colorado revealed that Hispanic women reported more SUI (odds ratio 1.7, $P = 0.005$) and mixed stress and urge urinary incontinence (MUI) (odds ratio 1.8, $p = 0.005$) than did non-Hispanic Caucasian women.⁴ According to year 2000 Census data, 32.8 million Hispanics reside in the United States and by the year 2050, one in four women will identify her ethnicity as being Hispanic/Latina.⁵ Therefore, the prevalence of PFDs among Latinas is expected to rise with the growing Hispanic population.

To date there are few studies that have addressed how Latinas experience and understand PFDs compared with other ethnicities/races. It is important to consider that an overwhelming percentage of Latina patients may have limited English proficiency, as well as inadequate health literacy. With complex diseases such as pelvic organ prolapse and urinary incontinence, it may be more difficult for Spanish-speaking women to comprehend their disease processes and treatments. Past research has demonstrated that patients with limited health literacy and/or limited English proficiency tend to have poor comprehension of physician's instructions, poor interactive communication, and report dissatisfaction with patient-physician communication.⁶⁻⁹

Considering that Spanish-speaking women constitute one of the largest growing populations in the United States and make up a significant amount of women who have pelvic floor disorders, it is important to evaluate the experience and perceptions of Latinas with pelvic floor dysfunction. Furthermore, it is necessary to determine what barriers might prohibit Hispanic women from comprehending their pelvic floor disorder and adequately obtaining information about proper treatment(s) for their condition. With the goal of evaluating the perceptions and barriers that Spanish-speaking patients experience, we sought to assess the effect of the initial visit with a female pelvic medicine specialist on disease understanding among Spanish-speaking Latinas with pelvic organ prolapse and/or urinary incontinence.

MATERIALS AND METHODS

Patient Recruitment

Approval was obtained from the Olive View-UCLA Medical Center Institutional Review Boards and women were recruited from urogynecology clinics within the Los Angeles County Healthcare System. All women gave written informed consent. Women were eligible to participate in this study if they were primarily Spanish-speaking and if they had received a referral or had a chief complaint suggestive of pelvic organ prolapse (POP) or any type of urinary incontinence (UI). Potential subjects were excluded if their primary language

was not Spanish, they were younger than 21 years, or if they had cognitive deficits or psychiatric conditions prohibiting effective interviewing.

After medical charts were screened by chief complaint, patients who had symptoms suggestive of stress urinary incontinence (SUI), urge urinary incontinence (UII), mixed urinary incontinence (MUI), and/or pelvic organ prolapse (POP) of any anatomic compartment at any stage were recruited at the first office visit. Patients were asked to participate in a short interview session with a trained Spanish-speaking female research assistant before and after the physician encounter (Appendix 1). In addition, patients were given the Spanish-validated Pelvic Floor Distress Inventory (PFDI) survey to assess symptom.¹⁰

Health Literacy Assessment

The Short Test of Functional Health Literacy in Adults (S-TOFHLA) was administered to each patient.¹¹ This seven-minute Spanish-validated questionnaire was administered under the supervision of a trained female research assistant and consisted of 36 reading comprehension questions. The S-TOFHLA questionnaire is graded on a scale from 0 to 34 with scores from 0-16 indicating inadequate health literacy, scores from 17-22 indicating marginal health literacy, and scores above 22 demonstrating adequate health literacy.

Patient Interviews

After completing the health literacy assessment, patients were asked to participate in a short interview with a trained Spanish-speaking female research assistant before and after the encounter with the physician. Before the physician interview, patients were asked two pre-scripted questions about their symptoms and presumptive diagnosis (Appendix 1a). After the physician encounter, patients were then asked two pre-scripted questions about their final diagnosis and treatment plan given by the physician (Appendix 1b). All interviews were audio recorded and transcribed verbatim.

Initial Physician Visit

Patients were counseled about their diagnosis and treatment plan after being examined by the physician. In order to capture real-world variation between providers, the counseling encounters were not standardized. Therefore, counseling included a range of explanations from physicians of different training levels including residents and attending physicians. Other factors that varied between encounters included Spanish proficiency of the physician and the use of pelvic models to explain the diagnosis to the patient. In cases where physicians were not Spanish proficient, interpreters were used and interpreter comments were included in the analysis of transcripts. All counseling interactions were audio recorded and transcribed.

Qualitative Analysis

All interview and counseling interactions were transcribed and analyzed qualitatively using constructivist Grounded Theory methods as described by Charmaz.¹² In Classic Grounded Theory works, Glazer and Strauss describe the discovery of theory as emerging from data separate from the scientific observer.¹³ Constructivist Grounded Theory takes the position that the observer is a part of the world studied and the data collected.¹³⁻¹⁵ Grounded theory provides guidelines for analyzing data at several points in the research process.¹² Quantitative research methodology is utilized to test a hypothesis. Grounded theory however, allows the researcher to search for a theory implicit in the data and is considered to be hypothesis-generating. The initial analysis involves line-by-line coding of the patient's own words with the purpose of finding key phrases that can be grouped together to form

preliminary themes.^{16,17} Next, these preliminary themes are compared and aggregated to form core categories or emergent concepts. Three different researchers analyze the data independently to reduce subjectivity and perform line-by-line coding in search of preliminary themes. These preliminary themes are then compared and combined to form emerging concepts. Throughout the data process, memos, or written explorations of ideas about the data and themes, were written to assist in integrating the analyses.¹⁶ We sought to interview approximately 25 women in order to achieve thematic saturation, in which new themes no longer occur with each additional interview.¹²

RESULTS

Twenty-seven women with pelvic floor disorders including POP (N=6), UI (N=11), and POP/UI (N=10) were recruited and enrolled in this study. The mean age was 55.5 (range 41-71 years) and the majority of women were Mexican with less than a high school education level (Table 1). The average S-TOFHLA score was 19, indicating marginal levels of health literacy. Results from the PFDI, indicated that the most bothersome symptoms in our study group were those due to urinary incontinence, followed by pelvic organ prolapse (Table 1). Preliminary themes were extracted from our qualitative data analysis incorporating key phrases directly from patient interviews before the physician encounter, during the encounter, and after the encounter (Tables 2-4).

Table 2 provides examples of representative patient quotes before the physician encounter used to exemplify the preliminary themes extracted during data analysis. The first preliminary theme demonstrated that patients had a poor understanding of anatomy. Patients' often times used the word "bola" ("ball") to describe pelvic organ prolapse. Similarly, patients used the word uterus and bladder interchangeably without knowing what compartment was actually prolapsed. For several patients this was the first time they had seen pelvic anatomy models and/or pictures. The second preliminary theme identified was that patients felt desperation and helplessness with their symptoms. As one patient explained, "One gets to a point where you stop feeling like a woman because you feel so uncomfortable." The last preliminary theme focused on complete reliance on the physician to solve the patients' problem, a reliance that was present before the physician encounter. It was common for patients to also rely on the physician for their decision-making. Prior to meeting the physician, one patient stated, "It's up to the doctor to decide what to do with me. I will do whatever she says."

During the counseling encounter the patient and physician were audio-recorded. Preliminary themes were extracted that pertained to each of these two roles. The first preliminary theme relating to patient perspectives was that patients sought out the physician's opinion throughout the entire encounter. Patients would commonly ask the physician what they recommended or would often say, "tell me what to do". The second preliminary theme identified was that patients feared both surgery and pessaries as treatment options. Patients commonly inquired about risks associated with them, and how each treatment would affect their daily lives. Nevertheless, even with the fear of surgery and pessaries, only 15 of the 27 women asked detailed questions about their condition or treatment options. Lastly, patients often turned to religion for comfort during the physician encounter (Table 3).

Additional preliminary themes related to the physician's perspective. The first preliminary theme demonstrated that physicians commonly avoided medical terminology and used simple words to describe the diagnosis. For example, one physician described a patient's MUI as having a "urine problem" and explained to the patient that it was a problem with "leaking urine without control and leaking urine with coughing, laughing, and sneezing". However, the physician never used stress or urge urinary incontinence. The second

preliminary theme identified was a lack of Spanish proficiency in some physicians. It was common for physicians to use broken Spanish and English or “Spanglish” during counseling of patients. In addition, several physicians spoke for several minutes at a time without pausing. This had the effect of bombarding the patients with information and not giving them the opportunity to ask questions. The third preliminary theme focused on the physicians’ emphasis of pelvic floor disorders not being life threatening. In most encounters physicians initiated the counseling session by assuring the patient that several women suffer from pelvic floor disorders and that the condition was not imminently dangerous.

The final preliminary themes were extracted from analysis of the patients’ words after the physician encounter. First, patients had a good understanding of treatment, despite a poor knowledge of diagnosis. When asked their diagnosis and treatment, one patient responded, “The names are just too difficult, but I have three problems. One with the bladder, and something about urine, and with my uterus, but who knows what it is. My treatment includes exercises (Kegels), a vaginal cream that I’ll put on, and she told me about a surgery I could have in the future.” The second preliminary theme was an even greater difficulty in naming all diagnoses given in cases where more than one diagnosis was present. Patients could usually name or describe their POP, but often times struggled in remembering or differentiating between the two types of incontinence in the setting of mixed incontinence. The third preliminary theme was a tendency to describe symptoms rather than name their actual diagnosis. For example, patients often described their “bladder/uterus falling,” but were unable to give the specific prolapse diagnosis. The fourth preliminary theme identified was that patients relied on the physician’s recommendations without wanting to make any treatment decisions themselves. Patients were frequently unsure about what treatment option to choose and would frequently ask the physician, “What should I choose?” or “Just tell me what to do.”

From the several preliminary themes relating to patient and provider communication, three main concepts emerged. First, we determined that the women in our study lacked knowledge about their condition both before and after the physician encounter. There was only minor improvement in knowledge about these conditions despite extensive explanations using pelvic models and/or interpreters.

The second concept identified was that patients seemed to be overwhelmed with the amount of new information being given to them, despite being assured that their condition was not life threatening. One patient said, “The words she (the physician) used were too hard to understand. All I know is that I have three problems.” Several women were unable to recall their diagnoses as shown in Table 5. However, some women were able to recall their treatments even if they did not know their exact diagnosis. Patients not only received too much information at one time, but also felt overwhelmed because of desperation, concern, and fear about their condition. Several patients described being worried about their pelvic floor condition because they thought it could be cancerous.

The final emergent concept that arose was that patients placed complete trust in the physician and ultimately relied on the physician to make decisions for them. Even before meeting the physician, patients were already anticipating and expecting the physician to take full control and responsibility in managing their care. Figure 1 incorporates the three emergent concepts illustrating a cycle of misunderstanding that patients struggled through as they attempted to gain information about their pelvic floor condition. Patients were left feeling uncertain and insecure after their initial visit and ultimately deferred all decision-making to the physician.

DISCUSSION

From our interviews and analysis of transcripts, it became evident that Spanish-speaking Latinas with poor health literacy lacked understanding their pelvic floor disorder and were ultimately left feeling overwhelmed. They therefore relied heavily on the physician for decision-making. Several factors influenced this lack of understanding, including inadequate or marginal health literacy. Lack of disease understanding in women with low health literacy can be further explained by a study that demonstrated that patients with low health literacy had poor receptive (physician to patient) and proactive (patient to physician) communication.¹⁸ Although this also held true for English-speakers with low health literacy, the difference was more notable in Spanish-speakers.¹⁸ From our own analysis, it became evident that the Spanish-speaking women in our study often did not understand information given to them, although they often times nodded and verbalized understanding. It is possible that women were too embarrassed to reveal that they truly did not understand the information being given to them. Another reason may be that the women themselves actually believed they understood, but only after being asked to recall their diagnosis did it become obvious that they actually did not comprehend their condition. Patients in this study also had difficulty comprehending their condition because of poor knowledge of pelvic floor anatomy. For several women, this was the first time they had ever seen models or pictures of the female pelvic floor and in certain cases women could not differentiate between the bladder, vagina, and uterus. Considering the complexity of pelvic floor anatomy and this being the first time women were shown their anatomy, it seems inevitable that this would create a difficult environment for our study population to be able to comprehend their pelvic floor conditions.

Another major barrier to patients' lack of disease understanding was a lack of Spanish proficiency in physicians participating in our study. Although some of the physicians were fluent in Spanish, several physicians struggled through the encounter with broken Spanish or required professional interpreters. Prior data has shown that in Spanish-speaking patients with low health literacy, patient-physician communication suffers when the physician and patient do not speak the same language, even if a professional interpreter is present.¹⁸ Although the interpreters in our study gave more detailed explanations and used more understandable terminology than the physicians, there was not a significant improvement in disease comprehension when interpreters were present. Our findings demonstrate the importance of language concordance in a population with low health literacy.

The second major concept that emerged from our qualitative analysis was that patients, who were uncertain and scared about their condition before seeing the physician, left the encounter feeling confused and overwhelmed by the amount of information given to them. Although most physicians emphasized that pelvic floor disorders were not life threatening, women were nonetheless left worried and without a clear understanding of their diagnosis. A significant factor influencing this problem was that the majority of women had more than one condition and as a result, physicians had to give longer explanations. In cases where extensive explanations were being given, the physician was more rushed than usual and did not always explain clear distinctions between the conditions. Patients were often left confused and wondering what the difference was between concomitant conditions, such as mixed, stress, and urgency urinary incontinence.

Furthermore, physicians did not always elicit understanding from the patient and instead would talk without pausing and allowing the patient to ask questions. Data from a literature review on the role of health literacy in the patient-physician relationship recommends limiting the amount of information given at each interaction, repeating instructions, and using a "teach back" method where patients are asked to demonstrate understanding by

repeating what the physician said.¹⁹ We found that several of these methods were not utilized throughout the physician encounters in our study, possibly due to lack of knowledge on the part of the provider and lack of time available to serve such a high volume of patients in the clinic.

Another major contributor to our study population feeling overwhelmed was the lack of patients being proactive throughout the encounter. Patients were not aggressive in their attempt to seek out information about their condition and, as a result, many of their questions remained unanswered. In a qualitative study by Julliard et al. attempting to understand why Latinas do not disclose information to their physicians, several factors were determined to play a role.²⁰ First, Latinas were less likely to interact with their physicians if they were embarrassed or if they did not feel they could trust their physician.²⁰ Secondly, time constraints made physicians less sensitive to the needs of these patients.²⁰ Lastly, language barriers prohibited effective communication and was further complicated when interpreters were present.²⁰ Considering that many of these barriers were present in our study, including time constraints and language barriers, the results of the Julliard et al. study may help explain why the women in our study were less likely to be proactive throughout the physician encounter.

The final concept that was elicited from our data was that the women in our study relied heavily on their physician to make treatment decisions and ultimately put all of their trust in the physician. Reasons for not actively participating in decision-making may be due to cultural differences in motivational processes. Although our healthcare system has shifted away from a paternalistic way of treating patients, and has pushed for a greater degree of patient autonomy, Mexican-American patients have less participation in decision-making than Non-Hispanic Caucasians.²¹ Some cultural groups are characterized by high power distance in which reliant relationships of dependents on superiors dominate.²² In a prior health services study looking at cultural differences in patient communication during colorectal cancer screening, it was shown that some Hispanic patients preferred to have high power distance relationships, meaning that these patients looked up to their physicians for their authoritative voice, knowledge, and expertise.^{22,23} The women in our study depended on physicians and were comforted in having the doctor give a recommendation rather than being given autonomy to make their own decisions.

Other factors that influenced a patient's reliance on the physician were that the majority of the women in our study came into the encounter with the objective of finding a solution to their problem. With this in mind, several women focused more on their treatment instead of listening to the physician's explanation of the diagnosis. In addition, several women, upon being assured that their condition was not life threatening, felt they could just let the doctor manage their condition. The focus on treatment, as well as putting complete reliance on the physician, prohibited several women from truly understanding their condition.

In a similar study of disease understanding among English-speaking women with pelvic floor disorders, we previously determined that English-speaking patients with adequate health literacy also lacked knowledge about their pelvic floor disorders and tended to focus more on treatment than their specific diagnosis (unpublished data). In addition, our prior work involved focus groups of aging women with overactive bladder symptoms, and demonstrated a great deal of misunderstanding about their condition and its causes.²⁴ Although both English- and Spanish-speaking groups cared less about the actual diagnosis and focused more on treating their bothersome symptoms, the Latina patients in our study were far more overwhelmed with the information given to them and, as a result, reported that they relied on the physician to make decisions much more often.

The use of grounded theory methods allows for description and analysis of patient views and subjective themes, which can help explain patients' perceptions about their disease.²⁵ Qualitative analysis is valuable in creating theories and generating hypotheses, which can later be used for quantitative studies.²⁵ There are limitations to this study design. First, our patient population may not be representative of patients as a whole because we recruited patients from one public hospital-based clinic. Furthermore, a general gynecologist or primary care physician referred all patients to the urogynecology clinic; therefore our study may not provide an accurate description of patients in the primary care or gynecology setting. Our study population may also not represent all Latino ethnicities because the majority of our patients were of Mexican descent. In addition, physician explanations were not standardized, though each physician had been trained in counseling by a urogynecologist. We purposefully did not standardize explanations in order to identify potential gaps in the physician-patient interaction that could affect patient understanding. In order to identify inconsistencies in patient counseling, all patient-physician encounters were audio-recorded and analyzed. The differences in explanations were accounted for when determining how much information the patient was given about her disease. Finally, a repeated criticism of grounded theory methodology is the bias associated with individual researcher preconceptions.²⁶ In order to avoid the subjectivity effects of the researcher, we had three different researchers (clinician and non-clinician) individually code transcripts and develop preliminary themes and emerging concepts.

The use of grounded theory to analyze interviews of Spanish-speaking Latinas with pelvic floor disorders revealed that this specific population of women had difficulty understanding and retaining information regarding their disease process. Patients who had more than one condition, those who had physicians that lacked Spanish proficiency, and/or patients who had interpreters present all appeared to have more difficulty understanding their diagnosis. Overall, the women in our study relied heavily on the physician for treatment recommendations and guidance, putting complete trust in the physician throughout the entire encounter. Our findings emphasize the need to improve and convey facts to patients in a manner that is compatible with their cultural learning process. Furthermore, communication with these patients can be improved if physicians foster a trusting relationship that allows patients to openly ask questions about information they do not understand. Further studies are needed to determine how we might overcome these barriers associated with Spanish-speaking patients' lack of disease understanding.

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APPENDIX

1a. Interviewer Script Before Physician Visit

1. "Can you please explain to me why you are here to see the doctor today?"
"¿Me puede describir brevemente por qué vino a ver al doctor hoy por favor?"
2. "What do you think your diagnosis or the problem will be today?"
"¿Cuál cree que vaya a ser su diagnóstico o su problema?"

1b. Interviewer Script After Physician Visit

1. "Can you please tell me what the doctor told you your diagnosis was today?"

“¿Me puede describir por favor cuál fue el diagnóstico que le dio el doctor?”

2. “Can you please describe the treatment options that your doctor offered you?”

“Por favor, puede describir el plan de tratamiento que le dio su doctor.”

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Figure 1.

Cycle of Misunderstanding: Despite a great deal of explanation regarding diagnosis and treatment options, patients continue to have uncertainty resulting in need to rely on physician for decision-making.

Table 1

Patient Demographics (n=27)

Mean Age (range)	55.5 (41-71)
Mean TOFHLA score (range)	19 (0-34)
Mean PFDI Symptom Severity score (range)	
Urinary Distress Inventory	108 (2-215)
Pelvic Organ Prolapse Distress Inventory	104 (0-258)
Colorectal-Anal Distress Inventory	80 (0-240)
Characteristic	% (n)
Country of Origin	
Mexico	70 (19)
El Salvador	14 (4)
Guatemala	4 (1)
Honduras	4 (1)
Nicaragua	4 (1)
Peru	4 (1)
Education Level	
No schooling	7 (2)
Less than high school	56 (15)
Some high school	11 (3)
High school diploma	18 (5)
Some college	4 (1)
Associate degree	4 (1)
Religion	
Catholic	70 (19)
Christian	26 (7)
None	4 (1)
Annual Income	
Less than \$10,000	33 (9)
\$10,000-\$19,999	30 (8)
\$20,000-\$29,999	7 (2)
\$30,000-\$39,999	4 (1)
Decline to state	26 (7)
Employment Status	
Employed for wages	26 (7)
Self-employed	11 (3)
Out of work and looking for work	11 (3)
Out of work but not currently looking for work	18 (5)
Homemaker	30 (8)
Unable to work	4 (1)

Table 2

Preliminary themes and representative quotes before physician encounter

Preliminary Themes	Representative Patient Quotes	Diagnosis
Poor understanding of anatomy	Ay Dios mío...siento una bolota. Una bolota que me sale para afuera. Me agacho y me la veo. <i>Oh my God...I feel a giant ball. A giant ball that is popping out. I bend over and I can see it.</i>	POP/MUI
Desperation with symptoms	La problema es que tengo la vejiga caída y me molesta bastante. Tengo necesidad de curarme. <i>The problem is that my uterus is hanging and it bothers me a lot. I have the need to get cured.</i>	POP/MUI
	Realmente estoy desesperada me siento mal porque voy muy seguido al baño. <i>I am frustrated, I feel bad because I go to the bathroom too much.</i>	MUI
	Como que uno ya deja de ser mujer porque ya se siente uno incomodo. No puede estar en un lado y tomarse una soda porque tiene que ir 10 veces al baño. <i>It's as if you are no longer a woman because you feel uncomfortable. You can't be at a place and drink a soda because you have to go to the bathroom 10 times.</i>	MUI
Reliance on physician	Vengo hoy a ver el especialista porque el es el que va decidir que va ser conmigo. <i>Today I have come to see the specialist because he is the one that is going to decide what he will do with me.</i>	POP/SUI
	Quero ver al especialista para ver que es lo que el me recomiende o que me manda hacer. Me va a dar un tratamiento o una cirugía. Lo que el me diga lo hago. <i>I want to see the specialist to see what it is that he recommends or what he tells me to do. He is going to give me a treatment or surgery. Whatever he says I'll do.</i>	POP

MUI, mixed urinary incontinence; POP, pelvic organ prolapse; SUI, stress urinary incontinence; UUI, urge urinary incontinence

Table 3

Preliminary themes and representative quotes during the physician encounter

Preliminary Themes	Representative Quotes	Diagnosis
Patient		
Seeking physicians' recommendation	Usted que cree que es necesario la operación? Como mira eso? <i>Do you think that the operation is necessary? What do you think about that?</i>	SUI
Fearing surgery	Doctor: Porque esta llorando? Patient: Aaaaayyyy! No se...por eso de la malla que voy a tener toda la vida. Voy a tener problemas. No? O consecuencias? Ay dios mío. Doctor: <i>Why are you crying?</i> Patient: <i>Oh! I don't know...because of the mesh that I'm going to have my whole life. I am going to have problems. Right? Or consequences? Oh my God.</i>	POP/MUI
Turning to religion for comfort	Me pongo en las manos del Señor. El puede ser que todo salga bien. Verdad? <i>I put myself in the hands of the Lord. He can make it so that everything will be fine. Right?</i>	POP/MUI
Physician		
Avoiding medical terminology	El sentimiento que hay una bolita en su vagina es porque esta cayendo poquito en la vagina. La soporta alrededor de su matriz no es muy fuerte. <i>The sensation that there is a little ball in your vagina is because it is falling a bit into your vagina. The surrounding support of your uterus is not very strong.</i>	POP/MUI
	Tiene problemas de pasar orina sin control. O tiene orina cuando tiene tos, riendo, estornuda. <i>You have problems with passing urine without control. Or you urinate when you cough, laugh, or sneeze.</i>	POP/MUI
Lack of Spanish proficiency	También podemos dar una es una disc...como se dice...yo no se...es un plástico un disco... pessaria que ponemos adentro de su vagina porque puede soportar su matriz y prevenir cayendo. <i>We can also give a, it's a disc...how do you say it...I don't know...it's a plastic, a disc...pessary that we put inside your vagina because it can support your uterus and prevent falling.</i>	POP/MUI
	Necesita pipi cada hora and then quitar sacar el pipi antes en el baño...Es problema con frecuencia siente su vejiga. Otra problema es nombre stress incontinence. So ese problema con sacar quitar el pipi con tos, con lift... <i>You have to pee every hour and then take out the pee before in the bathroom...It's a problem with frequency that you feel in your bladder. Another problema is named stress incontinence. So, that problem with taking out the pee with cough, with lifting...</i>	MUI
Focus on PFD's not being life-threatening	Necesita saber este es normal no es peligroso por su salud sus síntomas. Ok? Esta bien, muchas mujeres tienen ese problema. Ok? <i>You have to know this is normal, it is not dangerous to your health, your symptoms. Ok? It's fine, a lot of women have this problem. Ok?</i>	POP/SUI

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Table 4

Preliminary themes and representative quotes after the physician encounter

Preliminary Themes	Representative Patient Quotes	Diagnosis
Good understanding of treatment despite poor understanding of diagnosis	Como se dice... interec.... eso de la orina.... Irentencion... y que tengo la vagina... no sé... algo de la vagina... si se.. lo que no puedo, es explicar. Me dio opciones del ejercicio o la medicina y después....voy a volver a ver si se puede hacer la cirugía por el otro problema de la toz. <i>How do you say it...interec.... the urine thing.... irretention...and that my vagina is...I don't know...something to do with my vagina...I do know...what I don't know is how to explain it. He gave me options regarding exercise or medicine and later.... I am going to see if they can do the surgery for the other cough problem.</i>	MUI
	Ella lo dijo como...es como lo dijo...son muy trabajosos los nombres. Oh que tengo tres problemas. El problema de la vejiga y el de la ...ya no se que es orina o...y el útero... la matriz no se que sea...si los tres problemas tengo. Pues el tratamiento fue los ejercicios, pomada que me voy a poner, y lo que me dijo de la operación. <i>She said it like...it was how she said it...the names are very difficult. Oh, that I have three problems. The problem with my bladder and the one with...I don't know if it is the urine or....and my uterus...my womb, I don't know what it is...yes I have all three problems. Well, the treatment was the exercises, anointment that I am going to put on, and what he told me about the operation.</i>	POP/MUI
Not knowing all diagnoses given	La urgencia del baño. De la orina. Y la otra también que tengo.... Se... no puedo grabármela... algo del... del estrés.. que también tengo que tratar de hacer ejercicio. <i>The urgency to go to the bathroom. With the urine. And the other one that I also have...it's just that I can't remember it...something about stress...that I also have to try to do exercises.</i>	POP/MUI
	El problema la vejiga que se me desprendió y no sé qué más decirle. <i>The problem is that my bladder is dislodged and I don't know what else to tell you.</i>	POP/MUI
Describing diagnosis without medical terminology	Tengo el útero un poquito muy bajo o puede ser que algunas comidas me están irritando mi vejiga y por eso es que siente esa dolor... eso ardor. <i>My uterus is a bit too low or it could be that some foods are irritating my bladder and that is why I feel that pain.... that burning.</i>	POP
	Uuuhhmm...creo que la palabra es abs..abstinencia. Es que se le sale la pipi a uno poquito cuando estornuda, o cuando quiero ir al baño. <i>Uhm...I think that the word is abs...abstinence. Pee comes out a bit when I sneeze, or when I have to go to the bathroom.</i>	MUI
Allowing physician to make decisions	Me dijo que como es muy poquito lo que está bajo el útero me pueden poner como un red. Pero dice que ella no la recomienda porque dice que es muy poquito lo que lo tengo bajo. <i>She told me that since my uterus is only hanging a little bit and they can put a mesh there. But she says that she doesn't recommend it because she says that what I have hanging is very little.</i>	POP

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Table 5

Diagnosis in patient's own words: before and after patient encounter

Physician's Diagnosis	Patient Diagnosis (before)	Patient Diagnosis (after)
MUI	Posiblemente una pequeña infección o irritación vaginal. No se decirle exactamente eso me lo diría la doctor. <i>Possibly a small infection or a vaginal infection. I don't know exactly, that's what the doctor told me.</i>	Que posiblemente tenía algunos músculos de la parte abajo de la vagina un poquito débiles y que posiblemente sea que por eso hago mas pipi y tengo esa sensación de ir al baño. <i>Possibly some of my muscles from the lower part of my vagina are a bit weak and possibly that is why I pee more and I have that sensation to go to the bathroom.</i>
	Pues no le se decir. <i>Well, I don't know.</i>	Uhmmm...pues no se como explicarla no se. <i>Uhmmm...well I don't know how to explain it, I don't know.</i>
	Hay espero que no sea mal. <i>Oh, I hope that it's not anything bad.</i>	Uhmmm...pues no se el nombre que me dijo pero pues si que mi vejiga tiene presión. <i>Uhmmm...well I don't know what name he gave me but well yes, my bladder has pressure</i>
POP	Pues no se...hasta que no venga y me examine el doctor. <i>Well I don't know...not until the doctor comes and examines me.</i>	La parte de mi matriz abajo esta... esta como caída por muchos embarazos. <i>The lower part of my uterus is falling because of so many pregnancies.</i>
POP/MUI	Ay pues no sé. <i>Oh, well I don't know.</i>	Que lo que yo tengo de mi vejiga y de mi matriz...que no es muy riesgoso. <i>That what I have in my bladder and in my uterus...that it is not very dangerous.</i>
	Bueno negativo pienso porque no me siento bien. <i>Well negative I think, because I don't feel good</i>	Que tengo uhmmm...muy flojo... el... hay Diosito ya se me olvido. Tengo flojo el musculo por esa razones se me sale el pipi. La segunda, de que si tengo la vejiga muy baja. Son dos. <i>That it's uhm... very loose...the...oh my God, I forgot. My muscle is very loose, that is why my urine comes out. The second, that my bladder is too low. There are two.</i>
	Yo pienso que ser desprendimiento de la vejiga por hacer alguna fuerza. <i>I think that my bladder detached because of some force I performed.</i>	El problema la vejiga que se me desprendió y no sé qué más decirle. <i>The problem with my bladder is that it detached and I don't know what else to tell you.</i>
	Pues no lo sé. <i>Well I don't know.</i>	Si la urgencia del baño. De la orina. Y la otra también que tengo...no puedo grabármela... del... del estrés. <i>Yes, the urgency to go to the bathroom. To urinate. And the other one that I also have...I can't remember it...from the...from stress.</i>
	Mmmmm....pues que...pues que esta suelto el útero. <i>Mmmmm... well that...well that my uterus is loose.</i>	El problema de la vejiga y el de la ...ya no se que es orina o...y el útero... la matriz no se que sea...si los tres problemas tengo. <i>The problem with my bladder and with the...I don't know what it is, urine or...and my uterus...my womb, I don't know what it is...I have all three problems.</i>

MUI, mixed urinary incontinence; POP, pelvic organ prolapse